Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CLEARSKY MRI & NORTH DALLAS DIAGNOSTIC CENTER
12606 GREENVILLE AVE STE 110
DALLAS TX 75243

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-06-0703-01

MFDR Date Received

SEPTEMBER 19, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "We did receive payment for this claim however it was not correct the insurance only paid $800.37 there are cpt's codes that are not getting paid according to medicare [sic] fee schedulel [sic]."

Amount in Dispute: $2,999.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier, or its agent, did ot submit a position summary with their response to the request for medical fee dispute resolution.

Response Submitted by: American Zurich Insurance Co., 300 s. State St., One Park Pl., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 21, 2004	CPT Codes 73222, 73040, 73030, 76000, 23350, 99220 HCPCS Codes A4646, /a4550, A4515, A4647	$2999.00	$786.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out the guidelines for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 28, 2004 and August 12, 2005:
   - W3 – Additional payment made on appeal/reconsideration. Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided.

- 45 – Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance to a contract owned or access by a First Health Co.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307(e)(2)(C)?
2. Was the requestor reimbursed in accordance with 28 Texas Administrative Code §134.202?

Findings

1. The requestor stated on the *Requestor's Rationale for Increased Reimbursement or Refund* stated that "We did receive payment for this claim however it was not correct the insurance only paid $800.37…" The Table of Disputed Services does not contain the paid amounts on the table, nor did the requestor submit the EOB showing payment; therefore, the requestor has not met the requirements of 28 Texas Administrative Code §133.307(e)(2)(B) and (C).
2. In accordance with 28 Texas Administrative Code §134.202(c)(1), (2)(A-C), and (6) the Division has determined the following:
    - CPT Code 73222 – MRI, any joint of upper extremity; with contract materials. The insurance carrier reduced or denied this service with reason code 45 – "Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance to a contract owned or access by a First Health Co." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines. Medicare prices this code at $501.16 x 125 % = $646.45; therefore, reimbursement is recommended.
    - CPT Code 73040 – Contrast X-Ray of the shoulder. The insurance carrier used payment exception code W3 – "Additional payment made on appeal/reconsideration. Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided"; however, review of the EOB shows payment was ot made for this code. Medicare prices this code at $112.04 x 125% = $140.05; therefore, reimbursement is recommended.
    - HCPCS Code A4646 – Low osmolar contract material. This code has no published Medicare rate or Texas Medicaid rate; therefore, for products and services for which DMS or the Division does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value. The requestor billed $150.00 and the insurance carrier reimbursed this code at $150.00; therefore, additional reimbursement is not warranted.
    - CPT Code 73030 – X-Ray exam of shoulder. Pursuant to 28 Texas Administrative Code Section §134.202(b) for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. According to CCI edits CPT Code 73030 is a component procedure to CPT Code 73040 performed on the same date of service; therefore, reimbursement is not warranted.
    - CPT Code 76000 – Fluoroscope examination. The maximum allowable reimbursement for this code is $66.64 x 125% = $83.80. The insurance carrier reimbursed the requestor $79.34. Pursuant to 28 Texas Administrative Code Section §134.202(b) for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. According to CCI edits CPT Code 76000 is a component procedure to CPT Code 23350 performed on the same date of service, the use of an appropriate modifier may be used; however the requestor did not attach a modifier; therefore, additional reimbursement is not warranted.
    - CPT Code 23350 – Injection for shoulder x-ray. The maximum allowable reimbursement for this code is $$50.68 x 125% = $63.35. The insurance carrier reimbursed the requestor $241.29. Therefore, additional reimbursement is not warranted.
    - HCPCS Code A4550 – Surgical Tray. The requestor billed the insurance carrier $61.00 and was reimbursed $61.00 by the insurance carrier. Therefore, additional reimbursement is not warranted.
    - HCPCS Code A4215 – Sterile needle. In accordance with 28 Texas Administrative Code §134.202(c)(2)(B) this code has not published Medicare rate; the Texas Medicaid program prices this code at $0.16¢ x 125% = $0.20¢. Therefore reimbursement is warranted.
    - CPT Code 99220 – Initial observation care, per day. According to Medicare CCI Edits this procedure

should not be billed on the same date of service as procedure code 23350 without modifier -25. The requestor did not attach a modifier. The requestor billed $119.00 and was reimbursed that amount by the insurance carrier; therefore, additional reimbursement is not warranted.

- HCPCS Code A4647 – contrast material. The requestor billed the insurance carrier $150.00 and was reimbursed that amount by the insurance carrier; therefore, additional reimbursement is not warranted.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $786.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $786.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 9, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.